MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-024274
STATE FILE NUMBER

Registration District No. *365* — Primary Registration District No. *6047* — Registrar's No. *4*

FILED JUL - 0 1962

1. PLACE OF DEATH
a. COUNTY: *Saint Charles*
b. CITY OR TOWN: *Cuivre Township* — Length of stay in 1b: *4 yrs*
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): *Flatwood Rd-Highway Y* — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: *Missouri*
b. COUNTY: *Saint Charles*
c. CITY OR TOWN: *O'Fallon* — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS: *RR #1* (If outside, give location) — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) — First: *Curtis* — Middle: — Last: *Crittendon*

4. DATE OF DEATH — Month: *6* — Day: *22* — Year: *1962*

5. SEX: *Male*
6. COLOR OR RACE: *White*
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: *6-25-95*
9. AGE (last birthday): *66* — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): *Farm Labor*
10b. KIND OF BUSINESS OR INDUSTRY: *Farming*
11. BIRTHPLACE (City and state or country): *Kentucky*
12. CITIZEN OF WHAT COUNTRY: *U.S.A.*

13a. FATHER'S NAME: *DAN Crittendon*
13b. MOTHER'S MAIDEN NAME: —
14. NAME OF HUSBAND OR WIFE: *Carrie Crittendon*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): *No*
16. SOCIAL SECURITY NO.:
17. INFORMANT: *John Crittendon* — Address: *RR #1 O'Fallon*

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): *Acute Circulatory Failure*
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): *Coronary Occlusion*
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a):

PART III. If deceased was female was there a pregnancy in last 90 days? ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.):
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from *6-21-62*, to *6-21-62* and last saw him alive on *6-21-62*. Death occurred at *5:50* P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): *Joseph Elsey, DO*
22b. ADDRESS: *Winfield, Mo*
22c. DATE SIGNED: *6-23-62*

23a. BURIAL, CREMATION, REMOVAL (Specify): *Burial*
23b. DATE: *6-25-62*
23c. NAME OF CEMETERY OR CREMATORY: *Mount Hope Cemetery*
23d. LOCATION (City, town, or county):

24. FUNERAL DIRECTOR: *McLaughlin* — ADDRESS: *St Louis Mo.*
25. DATE RECD. BY LOCAL REG.: *June 27/962*
26. REGISTRAR'S SIGNATURE: *Martin F Piff*

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____   Signed___*H. G. Farris*_____
    Signature of Student Embalmer

                                                 Licensed Embalmer No.___*3384*___

                                                 P. O. Address_*St Louis Mo.*_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
    If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
    If this body is not embalmed, fact should be so stated above.